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**Appendix E - UNIVERSITY HONORS PROGRAM
SENIOR PROJECT - APPROVAL**

Name: Benjamin Crenshaw

College: Arts & Sciences Department: BCMB

Faculty Mentor: Dr. Glenn Graber

PROJECT TITLE: An Unheard Voice: Spirituality in
Health Care

I have reviewed this completed senior honors thesis with this student and certify that it is a project commensurate with honors level undergraduate research in this field.

Signed: Glenn C. Graber, Faculty Mentor

Date: 12/3/99

General Assessment - please provide a short paragraph that highlights the most significant features of the project.

Comments (Optional):

Combines a review of a wide range of literature from philosophy, theology, & health care with an empirical survey of hospital chaplains. The result is a careful critical analysis of important issues in medical education and health care practice.

**An Unheard Voice:
Spirituality in Health Care**

Benjamin Crenshaw
11/28/1999

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An Unheard Voice: Spirituality in Health Care

Project developed by Benjamin Crenshaw
Majors: Biochemistry, Religious Studies
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➤ *Abstract*

Before beginning any discussion on the role that physicians should play in the practice of medicine, one must first attempt to establish what the foundations of the practice are. It is illogical to critique the moral status of an institution if the institution does not rest on a moral foundation. So it is necessary to prove that medicine is in fact a moral art. This is a widely discussed topic, and the first part of this project will be devoted to a literature review of the current ideas.

Having proved the role of medicine as a moral art, one must then move on to consider the historical shifts in the moral foundation on which the institution is based. The adoption of pluralism as a societal ideology has made it clear that one cannot assume a common morality amongst diverse groups of people. Beliefs that once were assumed can no longer be presumed. Our differing social contexts that make up our particularity lead to multiple meanings for disease, health, life, and death. These different meanings, if not recognized, can lead to miscommunication within the doctor-patient relationship. A discussion of this phenomenon comprises the second part of this project.

The Humanistic endeavor to find the “Universal Man” has resulted in exactly what it hoped to avoid. Distillation of life down to a universal leaves no room for individual human particulars. Universalism, in its effort to transcend the subjectivity of individuals, fails to account for the fact that all views of reality are formed within a context, a set of particulars. The problem subsequently arises when one group claims that they have a unique hold on universal Truth.

Medicine and religion are both systems of authority. Conflicts over “turf” are bound to occur. The physician is at the center of conflicting ideologies, or more precisely, eschatologies. The presence of illness and possibility of death forces difficult questions. It is a turbulent time that can either lead to estrangement or companionship within the doctor-patient relationship.

The hope for medical professionals, if they are to provide for the overall well-being of their patients, requires that all life be viewed within its particular context. An appreciation of the value of the patient’s narrative is essential if manipulation is to be avoided. Due to the imbalance of power in the doctor-patient relationship, the onus lies on the physician to find his way in the narrative to which he has been thrust, but not to supply meaning or construct a patient’s life story.

The current form of medical education is partly to blame for the exclusion of religiosity from the medical environment. Doctors should be trained to practice empathy rather than sympathy. Great strides have already been made due to the efforts of several non-profit organizations. Now, more than fifty medical schools have incorporated issues of spirituality into their coursework.

While hopes that an appreciation of the religious context of the individual will make a significant difference in reestablishing communication may be naïve, it is a solid first step towards reestablishing trust within the doctor-patient relationship.

➤ ***Introduction***

There have been several conversations that I have participated in during the course of the last year and a half that have sustained the drive necessary to pursue and complete this project. One of the most profound was with a man whose wife had been suffering for years with a chronic debilitating muscle disorder. What prompted my interview was the anger and pain in his voice and eyes when he spoke of how the institution of medicine treated both him and, especially, his wife. During the course of the interview, he spoke of how inhumanely they were treated during a recent emergency room visit, forced to wait until morning to see a doctor, and repeatedly wakened during the night as indifferent and inconsiderate residents and nurses routinely “pricked” and prodded her to obtain samples. Yet, throughout the night, and with the multitude of individuals coming in to interact with this man’s wife, there was scarcely a word passing between them. The man I speak of is, in fact, a professor who has spent years researching the intricacies of muscle physiology. Yet, when he offered opinions and advice, they were given only the slightest attention, and frequently ignored. Ultimately, the physician could do little for them, and, thankfully, his wife’s condition improved slightly. He concluded, “If we had it [the hospital experience] to do over again, I don’t know that we would.”

Another encounter, more recent, again spoke to me and the heart of this endeavor. A lady was telling me of the awful experience she had had with some medication that she had taken. “The doctor didn’t tell me what I should and should not eat.” She stated that the doctor, in his interview, seemed disinterested in her ailment during their discussion, rarely looking at her as he addressed her. This breakdown in communication ultimately led to her becoming physically sick with the medication prescribed. She concluded, “When you become a physician, learn to talk to your patients, and tell them about things

like what they should and should not do with their medications. I am thoroughly disgusted right now.”

There have been countless other similar encounters over the years. Patients are growing discontent with the failures in the medical institution to communicate effectively, and to treat them as valuable human beings. This existential alienation is occurring concurrently with modern medicine’s growing emphasis on the utilization of sophisticated technology.¹ What constitutes the patient’s subjective reality is often neglected, particularly as physicians seek to reconstitute the patient as an object, and a broken machine for the physician to explore and repair.

Yet, how does one become more humane in one’s treatment of others? That is, indeed, a difficult question and dilemma. Students in home economics classes are often given “stuffed-bag babies” to teach them of the reality and demands of parenthood. Is there a similar practice that would help to teach medical practitioners?

If one addresses the medical dilemma as a problem in communication, then it would seem that there could be several routes to attaining the desired relationship. By addressing the patient as a person, to borrow a phrase from Paul Ramsey, relationships can be created and perhaps equally importantly, maintained during the hardships of illness and suffering. But what does it mean to address a patient as a person? Good question. If one learns to appreciate the particular world-view and perceptions of the other as valid interpretations, humility will be engendered, and communication fostered. It is humility, especially in this time of increasing lay knowledge, that will save the medical profession. It is humility that will bring the disenchanted back into the world of care.

➤ *Medicine as a Moral Art*

Many have spoken of medicine as a “moral art”, and in order to begin a critique of its current form, one needs to sort out what this means. What is it about medicine that makes it different from other business institutions? Perhaps, some would say, there is little or no difference, and they would be somewhat justified in their claims, particularly as managed care organizations place high premiums on cost-cutting and expediency. Yet, there is something in the healing relationship created through the agency of medicine that make mere transactional descriptions of medicine unsatisfactory.

William F. May, in an article titled “Code and Covenant or Philanthropy and Contract”, discusses the differences between the contractual relationships formed in most business settings, and covenantal relationships, which he sees as the proper form for the medical endeavor. “Contracts,” he states, “are signed to be expediently discharged.”² Contractual agreements, by nature, engender less incentive to develop a personal involvement, as there is an increased emphasis on the rapid production of results. The covenantal relationship, however, has a “gratuitous, growing edge” to it, and goals and objectives evolve during the course of that encounter. Covenants are aimed at the formation and deepening of a relationship, and it would seem especially appropriate in a relationship such as the one between doctor and patient. During the course of a disease and its treatment, there is mutual service involved as each draws upon the deeper reserves of the other. A contract cannot justify such a giving of one’s self. Perhaps, that is why they are so popular in our Western society.

The use of the contractual relationship in medical care is marked by irony. It is ironic because such an agreement simultaneously encourages two seemingly different reactions. As mentioned earlier, contracts foster minimalism (in the giving of one's self), yet they also tend to promote a perverse maximalism as the doctor practices "defensive medicine", which causes the financial costs of care to escalate as more and more tests are performed. The motivations for this are understandable, especially as the number of malpractice suits continues to rise. Fear is hardly a good motivator. Still, one may reasonably ask what is the common factor to these two different reactions. May states that "the link between these apparently contradictory strategies of too little and too much is the emphasis in contractual decisions on self-interest."³ The physician, in looking out for herself and her institution, fails in the service of her patient.

Yet, there are even more reasons, perhaps better ones, for referring to medicine as a moral, even religious, art. Throughout much of history, medicine was indeed a religious endeavor. At present, more than twenty percent of U.S. hospitals are faith-based, or, at least, were founded and sponsored by a religious community.⁴ However, since the liberal movements of the 1970's, the current state of bioethics tends to reflect predominantly secular values. What was once the material for theological discussion has become the arena of lawyers and philosophers.⁵

Despite the fact that American medicine has moved away from its associations with religion, medicine and spirituality continue to be related in many non-Western traditions. Acupuncture and herbal remedies are seeing a growth in popularity, and the Native American traditions have always maintained a definite relationship between spirituality and health. Indeed, physicians, like priests, are very frequently present at the great

mysteries of our birth and our death, not to mention during the in-between time, throughout our lives.

Physicians and the medical institution are looked to as a source of guidance and support, because to be in pain makes us realize our need for other people. Suffering makes us realize that we need help, and that we, contrary to popular Western belief, are not in total control of our lives. Illness can become an assault on our very sense of identity.⁶ It subverts our loftiest plans and the many more mundane aspects of our daily activities. By thus causing us to reconsider the world we inhabit, it can thereby ignite a sense of existential urgency – What does it mean to be human? to exist? to die? The present study discovered that over 33% of chaplaincy calls were for critically ill or dying patients (See Appendix I). The physician, who is called to be present during these times of great pain and tragedy, who has made a moral commitment to be present, is often exposed to our deepest fears and highest hopes. This is, potentially, one of the greatest privileges and potential downfalls that medical professionals are blessed with.

Roy Branson recalls how Max Weber consciously referred to the scientific vocation as a “calling”, intentionally including all the religious overtones that the word “calling” implied. Weber saw the central role of the scientific professions, such as medicine, in mediating the values and morality of the people in our modern, scientific age. As technological development has pushed but not overcome the boundaries of aging and dying, and religious interpretations of “man’s purpose” have been “superseded”, especially among the more rationalist thinkers of academia and humanistic efforts, death is set up as the enemy to be avoided at all costs. Whether this is a valid action is beside

the point. Once illness and death are set up as moral evils, any actions taken to postpone them will elicit confidence and trust.⁷

As theologian Karl Barth pointed out, there is a very natural reason to suspect the objectivity of the knowledge of a stranger. Yet, as a patient, one is required to give the physician confidence “at the very heart of our own history.”⁸ The very situation in which the patient finds himself requires him to trust the intentions of his caregivers.

Trust is vital in the doctor-patient relationship. Through his rigorous academic and situational training, the physician is equipped with better general scientific information, and the patient is left with no option but to trust in his application of that knowledge, or to seek help elsewhere. It is the patient who is in the unfamiliar environment, a world of powerful technology and strange faces, all altered by the presence of his or her illness. Therefore the onus for the establishment of trust lies particularly on the physician and other members of the medical institution.

Yet, how does one engender trust? This is a similar question to the one cited in the introduction of this paper. The emphasis of this paper lies in strengthening communication with the goal of building trust in mind. Communication can be improved by improving the perception of a number of social and personal phenomena. This paper focuses on what humans have lumped together under the rather vague term of “religion”. Religion and religious themes CAN be meaningfully incorporated into the discussion between doctor and patient, and it must be, if the voices of religious individuals are to be taken seriously. A failure to communicate disempowers those who are already weakened by infirmity.⁹

While most other businesses may prosper without ever addressing religious issues, what is at stake in health care that is of the utmost concern is the patient, not the business. To be human is to be enmeshed in a particular context, with particular beliefs and events shaping both experience and those beliefs. “One is defined as a person by one’s unique set of interrelationships.”¹⁰ To treat the patient as a person requires cognizance of those interrelationships. Healers are not meant to be overpaid mechanics, but doctors threaten to become such through disguising their humanity as they simultaneously deny the humanity of their patients. Non-recognition or misrecognition can inflict psychological and moral harm through a conflict of interests, and develop into a subtle form of oppression. By “imprisoning someone in a false, distorted, and reduced mode of being”¹¹, by stereotyping religious belief, one is undoubtedly risking the misrepresentation of the patient’s interests.

“Religion does not deal with the soul and medicine with the body. Practitioners of both are too well aware of the inseparability of soul and body – or perhaps better, they know the abstractness of both categories.”¹² The World Health Organization’s holistic definition of health as a “state of complete physical, mental, and social well-being” sought to incorporate such non-somatic factors into its scope. Its recognition of such factors does much to commend it. Yet, it has justifiably received much criticism from medical ethicists such as Daniel Callahan. He points out that the degree of physical health that the medical institution can provide does not equal happiness, and it can never promise to be such. Thus, the role that medicine can play in the maintenance and restoration of health, as it is defined by the WHO, is limited.¹³ If so, then it would seem that there would be a great advantage in working with professionals across a broad

spectrum of expertise to bring about the restoration process. But to know which professionals to contact depends upon the peculiar context of the patient in question, a context that is rarely explored in any detail by the medical institution.

The fundamental and peculiarly vague terms of “health” and “illness” are culturally and contextually defined. The basic tenets of medical ethics: beneficence, nonmaleficence, autonomy and such, are viewed differently by people from their own particular worldviews.¹⁴ A working knowledge of contexts must include the religious context of the patient in question, for religion is a dynamic force in the lives of a majority of the world’s population. Approximately 93% of adults in the United States express a belief in God, and 72% identify religion as the single most important influence in their lives. Yet, as indicated in the survey performed in this study, doctors are only “somewhat involved” in the spiritual care of their patients (See Appendix I). This could be due to the perception of religion as too fertile a source of prejudice and intolerance, and that it may be. It is also a means whereby one can truly appreciate the distinctiveness of one’s self and the other who is before him.

Surveys have shown that physicians, and especially psychiatrists, are very often less religious than the people they serve, at the same time as many patients increasingly turn to religion as a form of solace.¹⁵ In the present survey, it was noted that doctors who are themselves very spiritual tend to be more involved in the spiritual care of their patients than those who are not (See Appendix I). One would be tempted to argue that the religious disposition of the physician should make little difference as to how the physician should appreciate the beliefs of the patient. Unfortunately, this does not and possibly should not hold true in reality. On the surface, this statement may seem at odds

with the argument so far stated, but when analyzed carefully, it becomes clear that such an assertion is, in fact, a subtle reversal of the situation. Neither the patient nor the physician should be abstracted from their point of experience. It is inevitable that the particular world-view which one espouses will shape the way that other persons and their world-views are perceived. Tolerance and appreciation for different contexts is essential in our diverse society, and it is of the utmost importance in forming healthy relationships. Since the onus for establishing trust lies especially on the physician and the rest of the health care “industry”, this tolerance is primarily their responsibility. Nevertheless, nearly all the chaplains surveyed in the present study indicated that spiritual considerations are not given enough credence in the current health care environment (See Appendix I).

To conclude this discussion on the moral aspects of medicine, one must speak of the objective of medicine. The physician’s commitment cannot be simply to cure, for frustratingly often, the cure is unknown or unattainable. What the physician can and should be committed to, however, is to care, by being a presence and a covenant partner with which healing is sought. All other benefits flow from this willingness to be present, to not cut off the sick from the world of the living at their most trying time. Medicine, as it helps us to face and deal with the tragic nature of our existence, is inescapably a moral art.

➤ *From “Unity” to Plurality*

Americans have long lived under the fiction that theirs was a “Christian nation”. And for nearly all practical purposes, they could get away with making this claim. A survey

conducted in 1989 and 1990 indicated that, out of over 113,000 people surveyed, 86.5% identified themselves as Christians.¹⁶ While there has never been a “state religion” in America, traditionally, Christianity was very often the stated religion of the people in power, the founders of our nation, and the writers of our history books. Yet, in the present day, there has been a resurgence of native spirituality, and an increasing presence of other world and “new age” religious movements, including the movement away from religion altogether. What many perceive as the moral disintegration that has come about, especially in the latter part of the twentieth century, can be partially attributed to a reclaiming of individual, family, and cultural heritage, traditions that have been suppressed in some sometimes not so subtle ways. The American population has always had a heterogeneous mixture of religious traditions: Christianity, African tribal religions brought over with the slaves, Native American Spirituality, Judaism, Islam, and, more recently, Buddhism. There are countless others. The point is that a stance of methodological pluralism is required if one is to address and be concerned with our society as a whole. One must be willing to accept difference if one is to be truly concerned with society.

What came as no surprise in this survey was that 100% of chaplains surveyed in the Knoxville area indicated that the religious group to which they were most often called upon to serve were members of Protestant denominations of Christianity. This is a reflection of the cultural demographics of our area, the so-called “Bible Belt”. Eighty percent of the chaplains also indicated a Protestant grounding for their own service, while the other two indicated some form of interfaith approach (See Appendix I).

Interestingly, but not quite surprisingly, there was no representation of other major world religions in the pastoral care departments in three of the major hospitals in the Knoxville area. That should probably not be taken to mean that those other communities are not involved in the health care setting. Rather, there is just no one at the hospital full time to answer those needs.

Since the majority of American citizens, especially those in the southern states, identify themselves as Christian, it is tempting for one brought up in the south to never reflect on the conditions that brought that about. Likewise, many are brought up with a general ignorance of the richness of other religious traditions. But it will not do for those concerned with maintaining the welfare of society as a whole to be ignorant of those traditions or write off the differences as insignificant.

Secular and Christian perspectives are indeed distinct...
the dominance of the former at the expense of the latter
harms the patient whose world view is shaped by the
latter's values and assumptions. (Smith, p. 43)

For, just as the Christian perspective may differ significantly with a secular perspective in regards to the meaning of life, illness, death, and ethical concepts such as autonomy, so too will other religious perspectives differ from the Christian one. An awareness of how contextual differences shape the worlds that are inhabited is necessary if physicians are ever to truly empathize with their patients. Knowledge of these contextual differences is required if one is to establish true communication with the patient whose life is inevitably formed within their own world-view.

➤ *The “Universal Man”*

There is an innate tendency in humans, particularly those of Western society, to want to classify things, to seek out generalizations with which one can come to grips with the overwhelming complexity and variety of our world. Thus, animals as distinct as whales and monkeys can be simultaneously referred to by the generic term “mammal”. Indeed, there are similarities that make such a generalization possible, but there are also significant differences.

Religion and religious institutions have long been viewed as rich sources of prejudice and conflict. Historically, it is hard to argue with that fact. In a society seeking solidarity, then, it is somewhat understandable that there would be movements that sought to transcend the individual contexts of religious world-views to discovering the fundamental nature of existence and the life of the society as a whole. Secular humanistic endeavors, popular in academic and lay circles in the United States, have these goals in mind.

Yet, there is a dilemma created here. In an effort to create a more egalitarian society, as Bradford Smith puts it, proponents of secular humanistic ideologies have had to “homogenize” the unique existences of individuals. If we, as a society, are concerned with maintaining solidarity on a national level, then we cannot be too concerned if Jane Doe thinks Joe Schmoe’s interpretation of the Eucharist is barbaric. It is simply too time-consuming and self-involving to dive into and make sense of the individual’s world.

It also will not do to simply trivialize the differences, although this may, on the surface, be helpful, in our diverse society, in making things run more smoothly. Yet, this

is all too often what occurs today. Professionals are encouraged to "check" their system of beliefs "at the door" when engaging in discussion, as if those beliefs somehow validate or invalidate their argument. It is difficult to say what ramifications this kind of philosophy may have had in the development of our society. Relationships become superficial when there is a mutual restraint of what makes up our particularity. Our beliefs, no matter how irrational they may appear to the outsider, along with many other factors, make us who we are. To trivialize them in others is to trivialize them in ourselves and our individual worth as human beings.

Every person is unique. At the same time, every person is also a person in a community, a community which they draw upon and identify themselves with to give support, comfort, and meaning. As this is related to religion, people often identify themselves as Buddhist, Jewish, Christian, Muslim, Atheistic, or Agnostic. Even the general anarchist would seem to find common ground with other anarchists.

So, it would seem that there are general conclusions that one could make about the contextual differences of being a theist versus an atheist, of being a monotheist versus a polytheist, of being a Jew instead of a Christian, of belonging to the reform tradition rather than the orthodox. Yet, in order to come to the uniqueness of the individual whose experience is thus parcelled out, one would have to go to infinitely more levels of classification and subclassification. In other words, in order to understand human particularity, it is insufficient to have a general understanding of their characteristics, but, as Hauerwas points out, "one must also understand their history." One example, offered by Stephen Post in his discussion on psychiatrists who are insensitive to religious need, is a good example of what it can be like to be the object of classification.

How about trying to learn what I've learned as a child at home,
at Church, at Sunday school, so that you will be able to respond
to me in my particularity and complexity, rather than with some
abstract, formulaic, reductionist paradigm – of which my mind
and its workings seem to be a mere illustrative instance for you?

(Stephen G. Post, p. 366)

As William Paden puts it, “The crab does not see its crustaceanness.”¹⁷ The insider to a particular world-view, as an insider, is not prepared or comfortable with being grouped together with others who are viewed, by the insider, as being significantly different. The comparative anatomist, as the outsider, however, appreciates the crab both as a member of the family of crustaceans AND as a crab, thereby avoiding reducing the crab's existence to merely being simply another exemplary crustacean. By appreciating both its generalities and its uniqueness, one avoids what one may term pluralism's “dilution of the real”.

Secular humanism, in its efforts to transcend religion – to create an environment in which personal opinion is not a source of division – has, ironically, been forced to silence voices, the voices of religious tradition AND the patients that claim them. This is indeed a subtle form of oppression. It is ironic that an ideology with such egalitarian goals can have this result.

Hauerwas tells his readers that the moral commitment of the physician is to treat the immediate patient before him or her, not simply disease or the human race in general.¹⁸ For it is the individual, in all his particularity, that one is faced with and held accountable to.

One possible reason that medical discussions continue to neglect spiritual issues is because of their potential divisiveness and their tendency to provide deontological arguments on grounds that are held to be incontestable, and indeed, unverifiable in an

empiricist perspective. Ethics moved from out under the wings of religious institutions over the course of the last few decades. The presence of religious voices in ethical discussions has thus been progressively diminished. Daniel Callahan reflects on this marginalization.

Just as I had found that I did not need religion for my
personal life, why should biomedicine need it for its
collective moral life?

(Daniel Callahan, "Religion and the Secularization of Bioethics")

A by-product of this marginalization is the silencing of religious voices in the everyday practice of medicine. This can lead to a source of estrangement within the doctor-patient relationship. Patients want and need to be taken seriously, in all of their individuality, and they will often remain silent or avoid the medical institution altogether, if they fear that their beliefs will not be so taken. So, it would seem that communication would be greatly improved if patients felt that they were being taken seriously, and this means appreciating even their potentially radical interpretations of the world as valid within their own context.

➤ *Rationality Questions*

Steven Weinberg, Nobel Prize laureate physicist, recently voiced his opinion that there could never be a constructive dialogue between proponents of science and followers of religion because that would be giving religion "a kind of legitimacy it shouldn't have."¹⁹ In contrast to the perceived logical rigidity of physics, religious theory is often perceived to be hopelessly, infinitely flexible. Due to the modern demand for empirical evidence and the rationalist interpretation of reality, there is a tendency to think of reality as impersonal and to find it difficult to fit into the personal religious world-view. This

idea probably has its roots as far back as Greek thought (if not before) and the Platonic division between “body” and “soul”, material and spiritual. Yet, while scientism proclaims the supremacy of those things that are verifiable, empiricism has already been forced to make concessions to many unobservable phenomena. A brief list would include the concepts of space, time, depression, feelings of alienation, empathy, intelligence, loneliness, and pain.²⁰ None of these are directly verifiable, yet even the most radical empiricist would be foolish to pronounce them as being concepts devoid of value.

Many scientists and philosophers have noted that religious faith is characterized by a stubbornness to respond to the evidence. Yet, upon deeper, more critical reflection, science, once thought to be the realm of impersonal objectivity, is also shown to be theory-laden, and likewise dependent on value judgements, standards of excellence, and personal convictions. The evidence obtained is shaped by the technology used to seek it. “Ask a quantum entity a particle-like question and you will get a particle-like answer; ask a wavelike question and you will get a wavelike answer.”²¹ Niels Bohr’s concept of complementarity speaks loudly to those who analyze reality with pre-conceived notions and theories. Recognizing the subjectivity of all our sense impressions of reality is not to acquiesce to a rampant subjectivity such as Kierkegaard’s. There is an objective reality in which we exist; we simply do not have any means to verify it from an objective perspective.

Science and belief, particularly religious belief, cannot be said to be fundamentally irreconcilable, although they may be viewed, particularly in Western thought, as radically different. It is an epistemological question. The Oglala Sioux, typical of Native American Spirituality in general, had no word for religion in their native language. There

is no separation from the “mundane” aspects of daily life and the mysterious forces constantly at work surrounding them. Belief and practice were parts of the same whole.²² “Science” and “religion” both deal with things as they are – one does not logically exclude the other.

Julian Savulescu and Richard Momeyer claim that only by holding true beliefs is autonomy promoted. Rational beliefs, as they define them, are supported by verifiable evidence, and we have already noted the contextual nature of “evidence”. The case study they analyze is one that is often studied in medical ethics when it comes to religious belief, that of the Jehovah’s Witnesses’ refusal to accept potentially life-saving blood transfusions. Interestingly, they try citing inconsistencies in the interpretations of different biblical passages that are often used in the argument against accepting blood from a foreign source. They conclude that any “willful ignorance” to such inconsistencies is equivalent to irrationality. What Savulescu and Momeyer perhaps fail to realize is that nearly all religions and secular ideologies have aspects that can be viewed as inconsistent. Consistency and rationality are terms that only have meaning when established within a specific world-view, and as we have noted earlier, the insider/outsider relationship is marked by different perceptions. In the medical situation, especially when patients are facing the dissolution of their world, the words “rational” and “irrational” have little significance for the patient, for one tends to be no longer as concerned with consistency.

Tia Powell cites Stephen Carter’s The Culture of Disbelief, in which he forcefully argues that “religious beliefs are so poorly respected in academic circles and in other aspects of our society that reactions may range from casual dismissal to infuriated

attack.”²³ Personal experiences are not totally ignored when decisions are made by medical personnel and scientists, yet they do tend to be discredited. “Feelings” are deemed to be an inadequate basis for ethical decision-making.²⁴ In the current survey, almost all chaplains indicated that spiritual considerations are not given enough credence in the current health care environment (See Appendix I).

The fact that there is a larger percentage of atheistic or agnostic physicians than in the population at large may possibly lie in their having been educated to criticize opinions and beliefs that are difficult to verify. It may also stem from their frequent exposure to innocent suffering and death.²⁵ However, it is a false presumption to say that all religious patients are simply hiding behind religion in order not to come to grips with reality (the reality that the doctors themselves may believe in). In fact, radical religious beliefs are often deemed to be signs of delusional thinking and mental incompetence.

It would seem that the situations in which religious beliefs are often discussed would also be situations in which psychological concerns would arise. Yet, it also appears that psychiatrists and psychologists can be some of the least sensitive to religious ideas. This insensitivity is, of course, not confined to these specialties, and is partly to be expected of individuals who, generally, have little or no training on how to work with clients on religious and spiritual issues. In the current study, it was discovered that only 1.5% of chaplaincy calls were for psychiatry cases (See Appendix I). So, while they have no specific training in dealing with religious concerns, they are the group least likely to request the presence of the chaplaincy resource. One can infer from this the pathological significance that many psychiatrists associate with religious belief, and that, perhaps, they are attempting to help the patient learn to “walk without crutches”.

Stephen Post points out that the American Psychiatric Association's revised Diagnostic and Statistical Manual of Mental Disorders (1987) is replete with passages that may suggest a negative religious bias. Mention of religious beliefs is made in the entries for catatonic posturing, delusion, delusion of being controlled, delusion (grandiose), hallucination (tactile), illogical thinking, incoherence, magical thinking and mood-congruent psychotic features.²⁶ Psychodynamically and behaviorally-oriented psychiatrists often view religious behavior in terms of mind control. Recently, however, there have emerged several organizations of religious psychiatrists. While this could provide a tremendous resource for patients whose spirituality is important to them, a patient should not have to see one of these specialists for their beliefs to be respected. It will not do for either religious or non-religious practitioners of medicine to force or feel overly compelled to make others "come to their senses", i.e., believe what the physician believes.

The article by Julian Savulescu and David Momeyer has been the source for much of the debate in this section. Thankfully, they do include a retraction at the end of their discussion. "Those who claim to know Truth with certainty are at least as dangerous as those who claim to know Right and Good with certainty."²⁷ The physician who is so sure that his interpretation of reality is correct and is unwilling to accept his own fallibility is at least as dangerous as the religious zealot.

As the Muslim philosopher, Muhammad ibn al-Ghazali, states, "...faith in prophecy is to acknowledge the existence of a sphere beyond reason."²⁸ What modern intellectuals may be unfamiliar with, they generally assume to be impossible, or at least, implausible. If the intellectual were simply to reflect on the nature of his own experience, one would

gradually come to see the presuppositions necessary in forming that interpretation. A critical understanding of the presuppositions on which the intellectual's knowledge is based will humble those too proud to see alternate possibilities. The willingness to admit fallibility is one of the first steps to engendering trust. It is the one who claims infallibility who is to be feared.

➤ *Amidst Conflicting Eschatologies*

The sense of existential urgency often created during times of suffering and illness is never more dramatic than when one's world is threatened with dissolution and death.

"Suffering is the nudge to the religious question."²⁹

A healthy man can have no reason for seeing them [apparitions], considering that a healthy man is, above all, a material man; he must in consequence, in order to be well, live on or by his mundane life. But let him get ill, let his normal physical organization deteriorate, then forthwith becomes manifest the possibility of another world; and, in proportion to his increasing illness, his contact with the next world becomes nearer and nearer till death hurls him straight away into it.

(Dostoyevsky, Crime and Punishment, p. 219)

It is a difficult trial for people, including physicians, to be in the presence of those who are suffering and dying. And when so much suffering is perceived to be meaningless, it leaves one looking for answers – answers to questions for which we have no answers, and the religious aspects of our lives come to the fore, either to be clung to, altered, or rejected. In the present study, twenty-two percent of cases in which chaplains were called upon were either before or after surgery. Another twenty-two percent were for chronically ill patients, while over a third of chaplaincy calls were for critically ill or

dying patients, those in hospice care environments, and their families (See Appendix I).

People are seeking to make this existence make sense.

Physicians also have the temptation to distance themselves from those that suffer whom they are committed to care for. The “mask of professionalism”, or keeping one’s “professional distance”, are techniques whereby physicians maintain the integrity of their world, preventing it from plunging into the chaos of a world without meaning. The significance of these devices will be discussed in a later section.

For the risk of error is all the greater and the fall to death all the more jolting since the technological miracles have schooled us in the false hope that death might be avoided altogether.

(Stanley Hauerwas, Christians among the Virtues, p. 170)

For death is the potent reminder that our medicine is only an aid, not a cure, for our dying condition. Illness and death are the enemies of the medical effort. They may not be so for the patients, though.

Death, for the believer in a final judgement, could lead to despair as one fears to stand entirely alone before God, in one’s ultimate helplessness.³⁰ There is a finality to death in which the decision for or against God is rendered final and is imbued with cosmic significance.³¹ To die is to finally discover whether life with all its joys and troubles and despite all its variation is not vain.³² Yet, death may also be viewed by the religious person as a friend, a merciful release, and therefore not the evil to be avoided at all costs. As one can see by the different stances by religious and secular individuals on death, “two kinds of faith are battling each other.”³³

For many Christians, at least, there are two types of death - death of the body and death of the soul. Or perhaps it would even be better to say that there is a death whereby we are shed of our mortal bodies that have hindered our relationship with God, and a

death that is an eternal separation from God. This can be seen in the extremely symbolic language of 2 Corinthians 5. In this context, it makes sense if someone says that sin is death, and many equate the two. If one believes this, then it is understandable if one becomes extremely depressed and remorseful when sickness strikes, a depression that can be treated early if the physician knows what to look for.

Sickness, from the Old Testament standpoint, says Barth, is “an element in the rebellion of chaos against God’s creation.” Whereas one inclination may be to willingly submit to the judgement of the Creator, another may be to fight it at all costs. It is Barth’s opinion that to surrender to the illness, and to allow it to take its course, in its “obvious” opposition to the good will of the Creator, can only be disobedience to God.³⁴ The Christian concept of “the Crucified God” may lead its adherents to interpret their own personal suffering as a taste of what was experienced on Calvary. So, one can see that a single religious notion, that of equating sickness as a form of judgement, can promote a number of different reactions.

“Patient and physician become strangers to one another when the latter will not accept death even though the former sees it as the completion of his or her story.”³⁵ The doctor may push to prolong a life when that life no longer holds any value for the patient. Likewise, there may be pressures to withdraw treatment even when the patient is one for whom sin and death are to be averted as long as possible. In a situation where the patient’s specific religious context is left unexplored, the actions of the physician may tend towards manipulation, and the denial of autonomy.

There is also the difficulty of even using the term “autonomy”, especially when dealing with adherents of monotheistic tradition. For while certain humanisms may

center themselves around the individual and his autonomous choices, religions tend to center themselves around the concept of the sacred, be it a deity or a teaching (as in Buddhism). The religious patient may see the purpose for his life not as his own purpose, but as being part of a greater plan. In this sense, autonomy is a term that is often not appropriate with particularly devout and fundamentalist believers. Rather, theonomy, and how to live a God-centered life, even in death, becomes the issue. Alastair Campbell has noted that individual autonomy, at least in Christian ethics, can never be the sole determining factor for decision-making.³⁶

The question of medical and religious ethics is an interesting one, and how they interact when treatment decisions arise is perhaps even more interesting. We have already commented on the shift away from religious ethics and the marginalization of the religious voice. What makes these two endeavors antagonistic is the perceived incommensurability of their grounds for ethical argument. It is true that Christian ethics are specifically Christian because many of the arguments are grounded in the biblical teachings, especially the teachings of Jesus of Nazareth. And, for most Christians, there is at least, to some extent, something that is sacred and incontestable about the Bible. Yet, it is more often the particular emphases and interpretation of Scripture that give rise to the diverse positions that are tenable under the guise of religious ethics.

Let us take, for example, Augustine of Hippo, one of the most influential ethicists and theologians of all time. As Augustine dealt with issues such as suicide, politics, and just war, he was characteristically concerned with the issue of authority, and from his particular stance on authority, he was able to derive an entire system of ethics.³⁷ Since

the ultimate authority, as he saw it, was the word of God as contained in Scripture, he approached ethical questions from a fairly strict Biblical stance.

Joseph Fletcher's more personalist approach of situational ethics has, instead of Augustine's emphasis on authority, agape and mercy as its highest values.³⁸ When it comes to end-of-life decisions, he posits a sacredness of personality, and it is supreme over mere biological life. Another view, in contrast to this, is that of Paul Ramsey and many others who would state that we are not the owners, but rather the stewards of our lives, citing 1 Corinthians 6:19-20.³⁹ The point is, how one sets up one's values will inevitably shape how one approaches the questions that ethical dilemmas pose.

Doctors who truly want to care for those so inclined should know if and how someone seeks meaning in their suffering. By knowing the religious background of a patient and engaging them in sincere discussion, one can discover the values of the patient and thereby have some inclination as to how the patient will react to different courses of action. This can be a source of renewed focus for the physician as well, as she is able to learn what it means to suffer for this person, in this time. One discovers the hopes and fears of the patient before them, and gradually comes to see them as a person, with a family, with a history, with hopes and dreams that threaten to remain unfulfilled. One of the greatest services that the doctor can perform is to find ways to sustain hope, and often that hope is grounded in a religious doctrine or belief.

➤ *Narrative Medicine*

The patient history and the medical chart are the core means whereby today's physician is introduced to the patient and the patient's particular ailment. In contrast to the subjective and potentially misleading interpretations offered by the patient who

suffers, the information contained in the medical chart is succinct and conveyed through statistics, numbers, brief descriptions, and a complex system of abbreviations. It takes training to fully understand one, but it contains all information so far attained that is relevant to the case.

If one were to accept the proposition that health is merely physiological balance, then the above statement should cause no alarm. Yet for those who adopt a more holistic view of health, be it a variation on the WHO definition or something else altogether, there is a realization that “health” is more than the possession of the right numbers (cell counts, cholesterol levels, etc.). In addition, as noted before, characterizations and definitions of what it is to live a healthy life are dependent upon the cultural context of the patient attempting to describe it. Thus, the idea of the patient’s personal narrative, or interpretation of his or her life, and what it means, to them, to be healthy, come to the fore.

[T]he illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings.
(Kleinman, p. 49)

Let us begin with the first part of this statement. One of the many problems that suffering presents to the more philosophically-minded is its perceived meaninglessness. With the power of modern technology and the weekly breakthroughs in treatment that make the news headlines, it seems inconceivable that so much suffering, and especially the suffering of the “innocent”, the children, goes unrelieved. Illness becomes a point of incoherence in the life story of the individual.

How individuals restructure and reinterpret the events in their lives to give them coherence is indeed an interesting topic. The early Buddhist philosopher, Nagarjuna, would probably say that this is one of the great obstructions to experiencing the enlightenment that comes with experiencing things as they are, with no attachment to that conceptualization. Others, more antagonistic to religion, such as Freud, would indicate that this is a part of our personal neuroses, and our inability to accept the possibility of living in a world that does not make sense. The fact is, though, that for the majority of the world's population who claim to be religious, there is such an interpretive endeavor.

Laura Levitt, a Jew, speaks of healing as “the careful rebuilding of a life in the present that does not deny what has happened.”⁴⁰ To deny what has happened or to acquiesce to its incoherent nature introduces a break in the patient's narrative interpretation of her life. To simply restore physical health is to leave this fracture unaddressed. The story may continue from that point, but it no longer makes sense as a narrative whole. Is “Narrative Continuity” or “Narrative Wholeness” required for health? Once again, it depends on your definition. Amplification of illness has been shown to sometimes occur by association with various meanings and interpretations of symptoms and diagnoses.⁴¹ Thus, it would seem that one's psychological and mental health, and perhaps one's social health as well, could be greatly influenced by this inexplicable point of incoherence in the somewhat more comprehensible story of one's life. Should “Narrative Wholeness” be one of the specific goals of the physician? Probably not.

It seems that there is an innate tendency in humans to compress situations that would normally involve long explanations and lengthy discourses, and package them, as neatly as possible, into a powerful system of symbols. It is through models and symbols that

humans come to grips with the universe. A person, sufficiently trained in the intricacies of language, can easily use a metaphor to express a complex phenomenon as eloquently as any symbol in the literature of Marie de France. Marie leaves the symbol for the reader to unpack, and much of her success lay in her ability to communicate on different levels of meaning by leaving the interpretation open.

Patients, however, are placed in a difficult situation. They are put in the position where they must trust that the listener (the medical professional) is well-versed in the sometimes rudimentary, sometimes complex metaphorical language that is used to describe their experience, if the patient hopes to communicate the experience effectively. In the clinical setting, the patient is often brought face-to-face with the dissolution of her world through the havoc wrought by illness. Spirituality, and the use of religious language, can often help the religious individual to reconstruct the event and give it meaning – to make it part of one’s ongoing story. As Karen Lebacqz points out,

[The patient] needs a language adequate to give voice to that dissolution and to provide a framework within which it can be understood, accepted, and overcome. The language of science and reason is often too sterile for this task. The language of religion, precisely because it is often poetic and mysterious, is adequate to the task.
(Lebacqz, “Empowerment”, p. 810)

The ideal situation would be for communication to be improved by the appropriate use of the patient’s own metaphors in coming to terms with a foreign, biomedical language.

So far, we have left the question, as to who should be responsible for seeing to the “Narrative Health” of the individual, unanswered. Physicians, with all their technical, scientific training, are assuredly experts in handling questions of physical infirmity. The physician, also, has some experience of what it is to be human. However, physicians

tend not to be experts on the interpretation of interpretations, that is, of learning to handle the delicate issues that surround interpreting symbolic language, particularly when that language is composed of religious metaphors.

A good doctor is characterized by humility, and as Karl Barth states, he cannot promote what he terms “the strength to be as man”. Few physicians in the United States are religious specialists, and while they may refer those patients to the hospital clergy, it is perhaps not common enough, if one looks at the statistics (See Appendix I). The doctor’s job can never be to supply meaning for the patient, but to be present as the patient finds his or her own way. By removing or palliating the illness of the patient before him, the physician can make such a development of continuity possible. Alleviating physical symptoms is the nature of his expertise, and at this point he should withdraw, says Barth. Good doctors, and trustworthy people in general, are not afraid to acknowledge their limitations.

Due to the abbreviated, terse language of the medical history, there is, obviously, much information not written down that is valuable in constructing healthy, healing relationships. There is no “person” developed in a narrow case history – there is only a list of numbers and symptoms. The expanded history that incorporates the religious perspective of the patient is somewhat more complete and able to convey the particularities that make us who we are. Not surprisingly, the present study indicated that a majority of the information obtained by the chaplain concerning the patient’s religious background was obtained directly from the patient, which is probably as it should be. One responder indicated learning such information from a family member while another

indicated the nursing staff. None indicated obtaining knowledge about the religious situation of the patient from the physician (See Appendix I).

Yet physicians, as they are committed to care for the person who has come seeking healing, cannot be totally unconcerned with the narrative history of the individual, even if it is couched in religious or metaphysical terms. Physicians are involuntarily part of a world and a network of relations, fears, and dreams.

Each patient is a story. The doctor enters that story like a traveler lost in a forest, and more quickly than in the rest of life he learns to find his way... You start with jaundice. You learn it is a pancreatic cancer – cancer of the head of the pancreas blocking the bile ducts – you then learn about the life struggle of a cancer patient. Then it's no longer a cancer patient, but Julia Jones, John Smith, Bill Schwartz – their families, their marriages, their work, their hopes, their terror, their world. (Hiram Bender, as quoted by Arthur Kleinman, p. 215)

Physicians cannot avoid religious issues in dealing with their patients. The hospital chaplaincy resource can be an invaluable partner in the healing of the individual. It becomes a team effort, and neither possess the time or the resources to do it on their own.

➤ *Training Out Compassion*

Thus far, we have been content to witness to general attitudes and opinions regarding the spiritual care of religious patients. One could reasonably ask, what has given rise to this atmosphere of neglect, and how has it given rise to the sense of estrangement within the doctor-patient relationship? To the latter, one has tried to argue that it is because of the severing of ties and the silencing of voices that prevent the effective communication between patient and caregiver. The first question must also be addressed.

One could argue that the Western, post-enlightenment, rationalist perspective, has, to a large degree, discredited religious beliefs due to their subjective nature. Yet to be

overly involved in such an argument is to neglect the conditions of the “here and now” which continue this tradition. The issues of the present must also be reviewed, especially if one wishes the trend to change.

The pre-med/medical education, in general, leaves it to the students to figure out how to deal with the feelings they will possess in the future practice of their trade. To be constantly bombarded with the reality of suffering and chronic illness is to see one’s somewhat illusory notions, particularly about the effectiveness of care provided, shattered. Our medical knowledge, though prodigious, is and probably always will be insufficient for the alleviation of suffering. Cures are notoriously hard to come by.

In addition, it is often unprofitable for one to invest too much of one’s self and one’s time into individual cases, especially as the medical institution increasingly comes under the sway of managed care organizations and HMO’s. Legal issues also have the tendency to promote the efficient use of one’s time, for to do less is to risk a malpractice suit. These two influences, among others, have led to a remarkable trend in the education of tomorrow’s physicians.

To avoid error, physicians have become increasingly specialized, hoping that by knowing more and more about less and less, they will be prone to fewer mistakes, a strategy that ironically results in more mistakes, since as a matter of fact, the patient happens to be more than the sum of his parts. Unfortunately, he is increasingly cared for by a medicine that is something less than the sum of its specializations.

(Stanley Hauerwas, Christians Among the Virtues, p. 170)

Michael Polanyi has stated that we cannot appreciate a whole without appreciating its parts, but we can appreciate the parts without appreciating the whole.⁴² This is, as I see it, one of the pitfalls that threatens to undermine the undergraduate education in the natural sciences. Rarely are students encouraged to think holistically. Advancement of

the knowledge of a particular aspect of the whole (one science, say, embryology) generally advances our knowledge of the whole (life), but such progress is in danger of derailing and following its own course if the whole is not continually appreciated in all its complexity.

To draw an example from clinical biochemistry, the biochemist knows the dangers of denaturation, but she also knows that it is possible, though tedious, to recreate the original form. Denaturation is necessary for a proper characterization (sequencing and determining folding patterns) of proteins, but the resulting “soup” is “biologically inactive” – lifeless, if you will. Reductionism can never be the ultimate goal of the intellectual inquiry. If we scrutinize too closely the particulars of a comprehensive entity, its meaning can be lost or corrupted. The meaning of a mathematical theory of the frog lies in its continued relationship to the still tacitly known frog.⁴³ In other words, the sum total of the numbers contained in the medical chart do not add up to a human being. Aspiring physicians must be trained to appreciate the particular relationships that make up their own humanity and that of the patients they are committed to care for.

Keeping one’s “professional distance” is one tool whereby physicians are enabled to continue to serve the masses that come to the physician with their own personal crosses. It is also a means of disguising one’s own humanity and weaknesses. To become overly involved in the care of one’s patients is to share this suffering, and it can be a terribly frightening load, yet it is one that must be taken if one is to truly empathize with the one who suffers. Once again, we see the moral nature of the practice of medicine.

For most of us who struggle to be authentic in our work it is bad enough. But for those who hide their humanity behind professional and institutional barriers, who can’t handle the human side of sickness, it must be awful. No one prepares you for this, this

assault on your sense of being.

(Arthur Kleinman, p.216)

Practitioners are not trained to be self-reflective interpreters of questions of meaning and belief. Arthur Kleinman goes on to state that “They [medical students] are turned out of medical school as naive realists.”⁴⁴ Their naive conceptions are subsequently shattered during the grueling test known as the medical residency.

It could also be postulated that the dehumanization of young medical residents, as they are forced to run the gauntlet of residency training, contributes to the dehumanization of the patients that they subsequently see.⁴⁵ Stephen Schmidt, a sufferer of Crohn’s Disease, speaks of how he is “afraid of fifth-year residents...[that] tell me if my intestine does not open...I will have to have another surgery”. He goes on to mention how he hates “rounds held outside my room, rounds that do not include nurses, my wife, my children, my pastor, or even me...rounds done over me, around me, but not with me...”⁴⁶ Patients are routinely referred to, indirectly, as a conglomeration of empirical assessments, numbers, and statistics, as contained in their medical charts. It is the most expedient means of dealing with the large numbers of patients that they see. To overly care is to fall behind and lapse into negligence.

Lebacqz points out how humility is often portrayed as being antithetical to professionalism, and notes how the stereotypical image of the young, arrogant doctor is not totally unfounded.⁴⁷ Yet, it would seem that humility is what is needed to help re-establish the vital lines of communication that make the doctor-patient relationship possible. It could be argued that studies in the humanities force one to be humble about one’s own perspective, especially because one comes to see what presuppositions make that belief possible, and that these presuppositions are not universally accepted.

Since such heavy stress is placed, in clinical medicine, on combating disease, it is easy to see how many physicians could and do not comprehend the value, or even the plausibility of a narrative approach to life.⁴⁸ As noted earlier, the physician operates at the interface between the world of science and the humanistic world of personal experience. Yet, humanistic and moral training are often neglected, passed over without explicit reflection or criticism.⁴⁹ In the current survey, nearly all chaplains indicated that spiritual considerations, a means whereby one can establish such a narrative unity, are not given enough credence in the current health care environment (See Appendix I). Thus, the education of today's doctors is partly to blame for the inadequacies in the spiritual care of the patient population.

➤ *Empathy vs. Sympathy*

When Job's three friends, Eliphaz the Temanite, Bildad the Shuhite, and Zophar the Naamathite, heard about all the troubles that had come upon him, they set out from their homes and met together by agreement to go and sympathize with him and comfort him. When they saw him from a distance, they could hardly recognize him; they began to weep aloud, and they tore their robes and sprinkled dust on their heads. Then they sat on the ground with him for seven days and seven nights. No one said a word to him, because they saw how great his suffering was. (Job 2:11-13 NIV)

Stanley Hauerwas, in interpreting this portion of the Old Testament, speaks of the fear of encountering one who has faced severe tragedy and suffering, and relates a similar experience from his own life.⁵⁰ It would seem that at some point during everyone's life, they are brought face to face with someone who has suffered intense grief, and left speechless. The physician is called to do this on a regular basis. Personal suffering can be such that if one is to truly respect the one who endures it, one can do nothing better

than remain silent. To do anything else would be to enter the world of absurdity. All talk becomes meaningless chatter.

Yet, why do we continue to fear the encounter? Perhaps it is because it shatters our illusion of control. The reality of their pain points out how delusional our interpretation of the world can be. Perhaps we fear to fall into the same despair that engulfs the one before us, something that we feel we have no time for, especially if we are to move about and interact successfully in our own “world”. The illusion must be maintained if we are not to succumb to inefficiency. In medicine, this illusion take on the form of what Kleinman terms the “mask of medicine”.⁵¹ There is only so much of one’s self which one can invest in any one encounter if one is to maintain a sense of professionalism, or so we are taught.

Those who suffer still have a need to know that their suffering has not removed them from all meaningful human contact. Thus, Job’s comforters are to be commended for their willingness to simply be present in the face of unknowable suffering. They are also to be commended for their silence. It is when they speak that they utter foolishness, and God ultimately rebukes them for it.

There is also the question of timeliness. As mentioned earlier, as death and serious illness threaten, there is a tendency for convictions to waver. Believers can become practical atheists. Nonbelievers can draw on the habits of a faith community. Stanley Hauerwas thus describes Don Wanderhope, a character in Peter Devries’s novel, The Blood of the Lamb, to illustrate this point.⁵² One cannot enter an encounter with only a rudimentary knowledge of religious belief and hope to understand this time of

uncertainty. Insensitivity, in any form, be it intrusion or distancing, can destroy empathy and make the healing endeavor less likely to succeed.

Sympathy is one of the responses which we are conditioned to give when faced with those who suffer. Yet, if one takes the strict definition, it still implies a distancing of one's self from the other and the source of the other's pain. Empathy is intimately more involving, for in it lies a projection into the feelings of another, implying an existential presence in the midst of suffering. For, when we sympathize with someone, we claim to know something of that suffering, we pretend that it is similar to what we have ourselves experienced. However, suffering, especially from illness, is inescapably personal. It is impossible "to know your [another's] pain". For the pain that one endures is established within one's own particular history, is attached with whatever personal, social, or religious experience one attaches with it, and touches us as nothing external possibly can. Words are mere symbolic representations of that pain, and something of that is lost in attempting to share that suffering with another.

Sympathy involves the giving of respect, time, or attention to another's suffering...something across an existential distance... [while] empathy is much more intimate. It involves an existential presence of distinct selves occupying a very proximate conscious and emotional space. (Smith, p. 56)

Empathy, from Smith's perspective is infinitely more involving, and exhausting, than sympathy. It would seem that it could only be properly expressed with one's willingness to be present with those who suffer. Such is the nature of the physician's calling, yet the physician is trained to deal expediently with the case before him. The time required to learn from one another and one another's suffering is simply not available to the well-intentioned physician. There is no obvious remedy, but one can begin by understanding

the nature and limitations of the tool of the “mask of professionalism”. The truth of William May’s statement is frightening:

It will not do to pretend that one is the second person of the Trinity, prepared with every patient to make the sympathetic descent into his suffering, pain, particular form of crucifixion, and hell...It is important to remain emotionally free so as to be able to withdraw the self when those services are no longer pertinent. (May, p. 127)

“For it is our capacity to feel grief and to identify with the misfortune of others which is the basis for our ability to recognize our fellow humanity.”⁵³ Physicians deny their own humanity when they will not allow themselves to feel grief, and they deny the humanity of their patients when they are unwilling to be present. Grief is both blessing and terror. It separates us as few other things can, yet it can be one of the most powerful unifying forces, as witnessed by the coming together of a community. Such can be the nature of the doctor-patient relationship. We, as a society, do not have to settle for estrangement. All we need do is let down our guard.

...[D]o not tell Wolterstorff that death – the death of Eric – is “not really so bad.” Because it is. Death is awful...If you think your task as comforter is to tell me that really, all things considered, it’s not so bad, you do not sit with me in my grief but place yourself off in the distance away from me. Over there, you are of no help...To comfort me, you have to come close. Come sit beside me on my mourning bench. (Stanley Hauerwas, Naming the Silences)

➤ ***The Root of the Problem***

The lyrics to the song “Standing Up For Nothing”, written by Derek Webb and performed by Caedmon’s Call, speak volumes to the current dilemma in communication, and point to a means whereby the problem can be alleviated.

Lack of interest leads to
Lack of *knowledge* leads to

Lack of perspective leads to
Lack of *communication* leads to
Lack of understanding leads to
Lack of concern leads to
This complacency denotes
This approval denies
The truth. (italics mine)

It is seemingly impossible to force others to become interested in the concerns of religion. One can, however, provide a general working knowledge of belief systems, and it would seem that interest would proceed from that knowledge, in one form or another. Knowledge will inevitably lead to perspective, which will allow communication to occur, and communication is what we are after. This problem is being currently addressed, and will be discussed in the next section.

Besides the general disinterest of many involved in advanced scientific study with subjective interests such as religion, there seems to be another force at work that is preventing effective communication between doctor and patient. "Humility [and its recognition of personal limitations] motivates a mutual dependence."⁵⁴ Yet, humility is not a trait that one often associates with physicians. They are taught to exude confidence, and this is essential to cultivating the patient's trust and alleviating his fears. However, for the religious, there is an authority even beyond that commanded by the medical institution, and their means and goals may not be identical.

If physicians could learn to accept the relative nature of their authority, and become more acquainted with the basic presuppositions on which their ideology is based and how presuppositions shape their view of the world, humility would inevitably develop. And humility combined with confidence would reestablish the trust that is faltering in today's society.

Yet, how does one learn to accept one's own perspective as relative? It cannot be done without a significant amount of critical reflection. William Paden's comparativistic study of religion, developed most fully in his books, Interpreting the Sacred (1992) and Religious Worlds (1994) could provide some important tips. He conceives of each worldview as a "lens". Examples of such worldviews could be the scientific/rational worldview and the worldview of a Hopi spiritualist. Each lens is useful and provides insight as to the way worlds are curiously formed through interpretation. Yet to adopt a single lens, saying that one is superior over another, is overly simplistic, because by their very specificity individual worldviews are doomed to incompleteness.

When Paden speaks of the relativity of worlds and lenses, he argues that they are not necessarily mutually exclusive, if one realizes that the viewer only sees whatever the viewer's lens allows him to see, not to the exclusion of reality. A red lens cannot be used to see green light, and vice-versa. One should be critical of the notion that an objective, i.e. uninterpreted, reality is present in a universalistic sense, yet not fall into the trap of believing that all human interpretation is simply made up. As Paden points out, the main problem with such rationalistic questions is that they imply some realm where things can be objectively answered, not based on any interpretation. Such a realm is an impossibility.⁵⁵ Conventional truths are only observable from the interpretive lens of the world-view in question. This would include the truths of the medical perspective as well.

The other main issue which hinders effective communication is the issue of time. It is simply impractical to think that the physician can address all the needs of the patient in the relatively small amount of contact time. Therefore, cooperation is absolutely necessary between the different agencies that claim to be concerned with the welfare of

the patient, be it the nursing staff, the physicians, the chaplains and community clergy, or social workers.

The very nature of the hospital experience is often not conducive to forming relationships. The exception may be that of the more non-acute forms of medicine such as family practice. It is much easier to develop a relationship with one who one has seen over the course of years, than one with whom one interacts after they have been anesthetized. The time necessary to develop such meaningful relationships, sadly, is a scarce commodity, and the growing trend in managed care only serves to amplify this, as patient stays are shortened and expedient treatment and use of time bears financial significance. Indeed, in the current survey, there was, among the responding chaplains, ambivalence indicated toward the current trend in managed care practice, while, at the same time, availability of resources and managing the financial costs of health care were noted as areas which still need improving (See Appendix I).

➤ ***What's being done***

The weaknesses in the medical care “industry” pointed out in this project are not new discoveries. There has been much time and energy spent in remedying the situation, by specific non-profit organizations and by the institutions of medical education. The current survey showed that all chaplains seemed to react positively to the introduction of spiritual/religious issues into the training of health care professionals. Likewise, conduct and ethics were often cited as areas that needed significant improvement in today’s health care industry (See Appendix I).

Until the academic discourse of medicine is expanded beyond the languages of molecules and drugs to include the language of

experience and meanings, however, medical science will reinforce the profession's resistance to the problems of illness rather than contribute to the broadening of its vision. Research that avoids the human side of disorder places the profession and its practitioners in iron chains of restricted knowledge. So fettered, medicine and doctors are unable to address some of the most difficult yet essential questions in the care of the chronically ill; the physician is prevented from having a personal stake in the patient's condition, and medicine from applying moral knowledge to suffering. (Arthur Kleinman)

In the survey, one chaplain expressly mentioned that "training [was] needed to understand spiritual care and not just beliefs...Understanding how to address them could improve health and give more meaning and purpose to the situation." If physicians and those concerned with the welfare of the individual are to treat the patient as a person with their own personal ongoing story, then questions of meaning have to be resolved.

Steps have already been taken with this goal in mind. Elizabeth Johnson Taylor, et al., note that requiring an elective course on spiritual care improved the attitudes and perception of spiritual care and religiosity of 176 undergraduate and graduate student nurses.⁵⁶ The nursing profession has since included "spiritual distress" into its list of illnesses and disabilities.⁵⁷ Likewise, since 1995, more than 50 medical schools have incorporated spirituality issues into their coursework.⁵⁸ One product of these endeavors is the development of the "religious history", initially begun by the nursing staff, and, ideally, further explored by the hospital chaplain.⁵⁹ (See Appendix II)

One such course is the course offered at the medical institution at Vanderbilt University. Funded through a Templeton grant from the National Institute of Healthcare Research (NIHR), it is an example of the type of coursework that is being instituted in many of the medical schools across the country. These Templeton grants are awarded by the NIHR to fund coursework dealing with religious issues. Other recent and past

recipients include the Quillen College of Medicine at East Tennessee State University, Emory University in Atlanta, Case Western Reserve in Ohio, and Harvard University.⁶⁰ This specific course at Vanderbilt is designed in the following manner. The impact of religious practices and spirituality on health and disease is introduced in the Human Behavior course as part of the psychological consequences of illness. In the second year, spiritual and religious history is incorporated into the Physical Diagnosis course as part of the social history. In the third and fourth year, students have the chance to see this training as it is applied by working alongside attending physicians who already incorporate the belief systems of their patients in their day-to-day care.

Organizations such as the Carter Center's interfaith health program, the Christian Medical and Dental Society, and the NIHR are all making great contributions to raising the level of awareness about the value of appreciating individual religious belief as it influences one's health. Studies have shown that there is often a positive relationship between levels of spirituality and the patient's ability to better cope, and thereby better recover, from illness and injury.⁶¹ This does not say that the health care community should seek to proselytize to the patient to make them see the "error of their ways", but rather, that in patients so inclined, the resources of spirituality and religious belief can be valuable in the healing endeavor.

One of the main goals of these enterprises is to create, via the exploration of personal attitudes and beliefs, the environment and culture where it is acceptable to talk to patients at their deepest levels, to treat them in a more integrated manner. Addressing the religious needs of patients is one of many ways that communication lines between doctor and patient can be restored.

➤ *Where do we go from here?*

Despite all the great strides that have been made in education, in the reality of modern healthcare, it would seem that there is still much work left to be done. Only two chaplains surveyed indicated that they interacted with more than five doctors on an average day. Most interactions with patients were prompted by a request. However, it is the nurses as a group that are indicated as being the ones who most often request the presence of chaplains, probably due to their having the most (continuing) contact with patients and family members. Mention was made of the strong relationship between the Pastoral Care Department and the nurses partly due to the nurses' awareness of how helpful such service can be (See Appendix I).

The chaplains surveyed all saw between zero and twenty patients each day, with a slight majority indicating that they saw ten or less. One could have asked about the average duration of each visit and this may perhaps account for the fewer numbers than expected.

Healing involves all segments of the healing community – medical, lay, and clerical.⁶² So, why should there not be considerable overlap and cooperation between these areas? It is unrealistic to lay the entire burden on any particular group. The needs and the numbers of institutionalized patients are simply too great.

Empathy is a skill that improves with practice and the struggle to transcend one's own story.⁶³ Familiarity with any tradition should serve only as a guide, to be used non-presumptuously by the person seeking to comprehend an alternate, intensely personal, world-view. Training in religious generalizations is only a step, not the goal. To be truly

compassionate, the physician must be willing to deal with the patient as they present themselves, and not overly concerned with what they are preconceived to be.⁶⁴

Few people, including those in the medical community, realize to what extent one is dis-empowered by the clinical setting. When forced into the role of the patient struggling to express himself, the physician Oliver Sacks was shocked at how his voice was given so little attention.⁶⁵ Yet, from his situation, he was given a glimpse of what life is like on the other side of the healing relationship. The problem lies in learning how one is to teach compassion. Are we to subject each medical student to the same situation, as Bernie Siegel suggests, by diagnosing him with a chronic, debilitating illness and treating it as if it was real and force him to endure the fears, trials, and tribulations of a week in the hospital bed?⁶⁶ Undoubtedly, that would help to get the message across, but how could it be performed? If it were to be institutionalized, then undoubtedly, medical students would have heard of it, and therefore, possibly realize that it is all just role-play, cheapening the experience and possibly trivializing the suffering of others by artificially crossing “the existential Great Divide”, something that should be breached only with the utmost sincerity.

An education in medical humanities cannot be simply equated with humanistic care. Yet, if nothing else, a critical understanding of the presuppositions on which the intellectual’s knowledge is based will humble those too proud to see alternate possibilities. Genuine self-knowledge and critical reflection generally yield humility. It seems more likely that students of this approach will develop the requisite attitudes, tools, and skills that are necessary to practice medicine within its social and moral framework.⁶⁷

The medical profession has been advanced greatly and will continue to improve as recognition grows that spiritual needs are indeed important.

Notes

- ¹ Smith, Bradford Ray, Reestablishing Connections Between Bioethics and Christianity, p. 103
- ² May, William F., "Code and Covenant or Philanthropy and Contract", On Moral Medicine, p. 132
- ³ May, p. 132
- ⁴ O'Connell, Laurence J., "God and Public Health", p. 4
- ⁵ Smith, pp. v, 31
- ⁶ Mohrmann, Margaret E., "Stories and Suffering", On Moral Medicine, p. 352
- ⁷ Branson, Roy, "The Secularization of American Medicine", On Moral Medicine, pp. 18-19
- ⁸ Barth, Karl, "The Will to be Healthy", On Moral Medicine, p.10
- ⁹ Lebacqz, Karen, "Empowerment in the Clinical Setting", On Moral Medicine, pp. 806-807
- ¹⁰ Kasulis, T.P., Zen Action Zen Person, p. 9
- ¹¹ Powell, Tia, "Religion, Race, and Reason: the Case of L.J.", p. 75
- ¹² Hauerwas, Stanley, "Salvation and Health: Why Medicine Needs the Church", On Moral Medicine, p. 74
- ¹³ Callahan, Daniel, "The WHO Definition of 'Health'", On Moral Medicine, pp. 253, 258
- ¹⁴ Smith, p. v
- ¹⁵ Schreiber, Katrina, "Religion in the Physician-Patient Relationship", p. 3062
- ¹⁶ Goldman, Ari L., "Portrait of Religion in U.S. Holds Dozens of Surprises"
- ¹⁷ Paden, William, "Elements of a New Comparativism", p. 10; Interpreting the Sacred p. 75
- ¹⁸ Hauerwas, "Salvation and Health", On Moral Medicine, p. 75
- ¹⁹ Goldberg, Carey. "Crossing Flaming Swords Over God and Physics"
- ²⁰ Moberg, David O., "Spirituality, Aging, and Spiritual Care", in Well-being and the Elderly, p. 11
- ²¹ Polkinghorne, John C., Science and Theology, p. 31
- ²² Albanese, Catherine L., America Religions and Religion, p. 19
- ²³ Powell, p. 75
- ²⁴ Lebacqz, Karen, "Bio-ethics: Some Challenges from a Liberation Perspective", On Moral Medicine, p. 85
- ²⁵ Schreiber, pp. 3062-3066
- ²⁶ Post, Stephen G., "Psychiatry and Ethics", p. 367
- ²⁷ Savulescu, Julian and Richard W. Momeyer, "Should Informed Consent be Based on Rational Beliefs?", p. 284
- ²⁸ Watt. W. Montgomery, The Faith and Practice of Al-Ghazali, p. 78
- ²⁹ Schmidt, Stephen A., "When You Come Into My Room", p. 512
- ³⁰ Kierkegaard, Soren, as translated by Hong & Hong, Soren Kierkegaard's Journals and Papers, p. 337
- ³¹ Rahner, Karl, On the Theology of Death, p. 26 quotes John 9:4; 2 Cor. 5:10; Luke 16:26
- ³² Bultmann, Rudolf, Life and Death, p. 18
- ³³ Moberg, p. 12
- ³⁴ Barth, Karl, "Sickness and Illusion", On Moral Medicine, p. 244
- ³⁵ Hauerwas, Stanley, Naming the Silences, p. 124
- ³⁶ Campbell, Alastair, "A Response to Paul Badham", Studies in Christian Ethics, p. 17
- ³⁷ Gill, Robin, A Textbook of Christian Ethics, p. 467
- ³⁸ Gill, p. 10
- ³⁹ Ramsey, Paul, Ethics at the Edges of Life, pp.147, 156
- ⁴⁰ Levitt, Laura, and Sue Ann Wasserman, "Mikvah Ceremony for Laura", Four Centuries of Jewish Women's Spirituality, p. 322
- ⁴¹ Kleinman, Arthur, The Illness Narratives, p. 9
- ⁴² Polanyi, Michael, The Study of Man, p. 29
- ⁴³ Polanyi, Michael, The Tacit Dimension, pp. 20-21
- ⁴⁴ Kleinman, p. 17

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- ⁴⁵ Kleinman, p. 49
- ⁴⁶ Schmidt, Stephen A., "When You Come Into My Room", p. 512
- ⁴⁷ Lebacqz, Karen, "Humility in Health Care", p. 293
- ⁴⁸ Hauerwas, Naming the Silences, p. 125
- ⁴⁹ Smith, p. 104
- ⁵⁰ Hauerwas, Stanley, "Salvation and Health", On Moral Medicine, p. 73
- ⁵¹ Kleinman, p. 215
- ⁵² Hauerwas, Stanley, Naming the Silences, pp. 59-60
- ⁵³ Hauerwas, Stanley, Suffering Presence, p. 25
- ⁵⁴ Smith, p. 59
- ⁵⁵ Paden, Interpreting the Sacred, pp. 107-108
- ⁵⁶ Taylor, Elizabeth Johnston, et al, "Attitudes and Beliefs Regarding Spiritual Care", p.480
- ⁵⁷ Moberg, p. 17
- ⁵⁸ O'Connell, p. 4
- ⁵⁹ Smith, p. 288
- ⁶⁰ NIHR's website, <http://www.nihr.org/clinical/9899.html>
- ⁶¹ Tix and Frazier, p. 411
- ⁶² Mohrmann, p. 353
- ⁶³ Smith, p. 57
- ⁶⁴ Kasulis, p. 141
- ⁶⁵ Lebacqz, "Empowerment", p. 808
- ⁶⁶ Schwartz, Stephen G., "Holistic Health: Seeking a Link Between Medicine and Metaphysics"
- ⁶⁷ Kleinman, p. 266

Appendix I

In an effort to note some of the trends in the medical community in regards to spiritual concerns, a survey was performed of several hospital chaplaincy units in Knoxville, Tennessee. The applicability of such information gained is thus limited, but deemed to be at least partially representative of a typical southern “Bible Belt” community.

The survey itself was formulated from my own reflection after reading many of the works cited in this project. No previous examples of such a survey were found during my somewhat cursory research. Some questions lead into others, and one did have general notions about how the respondent would reply, though this did not always happen to be the case. In an effort not to skew the results, most respondents had little or no information as to how the results of this survey would be used. When initially issuing the surveys, I spoke with secretaries and a few of the chaplains, but, as I said, most had no such knowledge. This lack of information may be one reason why there were fewer respondents than desired.

A note on the survey population – yes, it was perhaps too localized in a particular cultural region to make broad-sweeping claims. Yet, the three hospitals involved in the survey were representatives of different affiliations. One was a public, HMO-owned and operated hospital. The second was a university teaching hospital. The third was religiously affiliated.

Survey for Hospital Chaplains

Note: Any and all participation in this survey is optional and confidential. Conclusions based on this survey will be attributed anonymously to "Chaplains in the Knoxville Area". Thank you for your participation.

1. Approximately how many patients do you visit on a given "typical" day:
 - (a) 0 – 10
 - (b) 11 – 20
 - (c) 21 – 30
 - (d) 30+
2. How many doctors do you interact with on a "typical" day?
 - (a) 0 – 5
 - (b) 6 – 10
 - (c) 10 – 15
 - (d) 15 – 20
 - (e) 20+
3. What type of situation, on a "typical" day, are you most often called upon (for the patient, family, or doctor)? If possible, give approximate percentages of cases which fall within these classifications.
 - (a) before / after surgery ___ %
 - (b) psychiatric ___ %
 - (c) chronically ill ___ %
 - (d) critically ill / dying ___ %
 - (e) general outpatient ___ %
 - (f) other (please specify) _____
4. How is it that you most commonly make the initial visit to see patients?
 - (a) random encounters (during rounds)
 - (b) request / referral
5. What religious community do you claim to represent?
 - (a) Buddhism
 - (b) Christianity – Roman Catholic
 - (c) Christianity – Protestant
 - (d) Islam
 - (e) Judaism – Orthodox
 - (f) Judaism – Reform
 - (g) Not affiliated with any particular religion
 - (h) other (please specify) _____
6. What religious community(s) are you most often called upon to serve?
 - (a) Buddhism
 - (b) Christianity – Roman Catholic
 - (c) Christianity – Protestant
 - (d) Islam
 - (e) Judaism – Orthodox
 - (f) Judaism – Reform
 - (g) Non-religious
 - (h) other (please specify) _____

7. How do you most often initially find out about a patient's religious background and present situation?
- (a) medical history
 - (b) nurse's referral
 - (c) family request
 - (d) direct from patient
 - (e) other (please specify) _____

8. Who most often requests your presence and/or services?
- (a) doctor
 - (b) nurse
 - (c) family member
 - (d) patient
 - (e) other

9. Based on your answer to #8, why do you feel that that is so?

10. Would you consider "spiritual health" to be an important consideration in health care? (yes) (no)

How involved would you say the doctor generally is, in regards to the spiritual care of patients?

- (a) very involved
- (b) moderately involved
- (c) somewhat involved
- (d) not involved

Do you feel that religious beliefs and considerations are given enough credence/respect in the current health care culture? (yes) (no)

11. Do you agree with this statement: (yes) (no)

"If doctors, in their training, were required to familiarize themselves with a critical understanding of their own system of beliefs, and to acquire a general working knowledge of other belief systems, he/she would be better able to understand the personal situation (context) of the patient, establishing better communication within the doctor-patient relationship, and ultimately improve the health care received."

If you answered no to the above question, why do you disagree?

12. Are you satisfied with the way health care is practiced today, in its progressively greater switch to a managed care environment? (yes) (no)

13. What area do you see that needs the most improvement?

- (a) technology
- (b) facilities / availability of resources
- (c) conduct (ethics)
- (d) personnel training
- (e) managing financial costs of health care
- (f) other (please specify) _____

Survey Results

Of the twenty-one questionnaires distributed, there were ten responses. While the group was thus quite small, there were definite trends in the responses. The population surveyed was described earlier as being at least somewhat representative of an area of the United States where religiosity is deemed to be high, that of the southern “Bible Belt”. The responses for each of the items listed in the survey will now be discussed.

- 1) The chaplains surveyed all saw between zero and twenty patients each day, with a slight majority (six of ten) indicating that they saw ten or less. One could have asked about the average duration of each visit, and this may perhaps account for the fewer numbers than expected.
- 2) Only two responses indicated that they interacted with more than five doctors on a given “typical” day. The rest indicate the category of between zero and five.
- 3) 22% of cases in which chaplains were called upon were either before or after surgery.
1.5% were for psychiatry cases.
22% were for chronically ill patients.
33% were for critically ill or dying patients.
11.5% were for general outpatient/ general admittance.

The remaining ten percent were divided among a number of different cases, including rehabilitation, geriatric patients, hospice care, and bereavement care of family members, the last two of which might also be included in the category of critically ill or dying patients.

- 4) A small surprise – most (seven of ten) indicated that interactions with patients were usually prompted by a request. From question eight, it was determined that nurses were indicated as being the ones who most often (six of ten) request the presence of

chaplains, indicated as due to their having the most contact with patient and family members, and mention was made in the response to question nine of the strong relationship between the Pastoral Care department and the nurses, attributed by one chaplain to the nurses' awareness of how helpful such service can be.

- 5) Reflective of southern society at large, 80% of the chaplains surveyed identified themselves as belonging to a Protestant tradition, with two responses indicating some sort of interfaith approach. There was no representation of other major world religions though that should probably not be taken to mean that those other communities are not involved in the health care setting. There is just no one there full time to answer those needs.
- 6) 100% of those surveyed identified Protestants as the religious community that they are most often called to serve.
- 7) Not surprisingly, a majority (nine of ten responses) indicated that the information obtained about a patient's religious background was obtained directly from the patient, which is probably as it should be. One response indicated learning such information from the family request, and one indicated obtaining such knowledge from the nurse's referral.
- 8, 9) Combined with observations in question four stated previously
- 10) While, as predicted, all surveyed responded that spiritual health is an important consideration in health care, most (seven of ten) indicated that doctors were only "somewhat involved" in that spiritual care. One chaplain noted that doctors who are themselves very spiritual tend to be more involved than those who are not. Generally, nearly all (seven of ten with three abstentions) indicated that such spiritual considerations are not given enough credence in the current health care environment.

- 11) All seemed to react positively to the introduction of spiritual/religious issues into the training of health care professionals.
- 12) There was ambivalence toward the current trend of managed care. Six of ten indicated that they were dissatisfied with current trends and there was one abstention.
- 13) Several cited conduct and ethics as the areas which needed the most improvement. Other areas mentioned were personnel training, availability of resources, and managing financial costs of health care. One expressly mentioned that “training [was] needed to understand spiritual care and not just beliefs...Understanding how to address them could improve health and give more meaning and purpose to the situation.”

Appendix II

There have been attempts to formulate a questionnaire to be used in developing the “religious history” of patients. One such questionnaire was recently one of the topics discussed on the discussion list-serv of the Carter Center’s IHP network. By adapting the information from the Spring 1999 Journal of Christian Nursing, Pam Evans, and RN, developed the following:

SPIRITUAL ASSESSMENT

ASSESSMENT QUESTIONS – ADULT

1. What gives your life purpose and meaning? What/who is the source of your strength and hope? What is your concept of God or a supreme Being?
2. What are your thoughts about your health in relation to your spiritual beliefs?
3. How has illness affected the way you view yourself?
4. How have you coped in the past through times of difficulty or pain? What religious rituals or practices are important to you?
5. How has this situation affected your thoughts about God/Supreme Being or the practice of your faith?
6. At the end of life, are there things you want to do or people you need to speak with? What unfinished business remains? Do you want to forgive anyone or seek forgiveness?

CHILDREN

1. How do you feel and who or what do you turn to when you’re in trouble, when you’re scared?
2. Tell me about any church or religious activities that you or your family participate in.
3. Can you tell me about God? Can you draw a picture of you and God?